CHAPTER 15 — DEATH AND DISMEMBERMENT CLAIMS

1500 Death Benefit Claim - Active Employee

Active employees, for the purposes of death and dismemberment claims, include individuals who:

- Are currently employed
- Are on a leave of absence or layoff with coverage continued by employee
- Have terminated employment within 61 days prior to death

In the event an active employee dies, the employer shall:

1. Call either MLIC or ETF to initiate the processing of death benefits.

2. Immediately complete a *Notice of Death* (ET-6301). The *Notice of Death* form is available from MLIC and on the ETF internet site at etf.wi.gov.

   NOTE: Last day worked is the last day that the employee was actively at work, not the date of death.

3. Mail the completed form to MLIC.

4. Explain in an accompanying letter, the basis used if estimated earnings are used to determine the amount of insurance.

5. Attach a newspaper obituary if available.

6. Indicate the family contact if known.

7. Enclose a certified copy of the death certificate. If a death certificate is not immediately available, mail the *Notice of Death* (ET-6301) to MLIC or ETF without it. If the employer is unable to obtain the certificate, MLIC will request it from the survivor.

NOTE: "Certified" means that there will be a statement either on or appended to the death certificate attesting that the document is a certified copy of the original death certificate. MLIC requires the certified copy of the death certificate before processing any claims.

8. Include the employer's name and telephone number in the event there is a question regarding the claim.

The *Notice of Death* form provides MLIC with the necessary information to initiate the life insurance death benefit process. The *Notice of Death* provides a space to indicate whether the employee died as a result of an accident. Although the death certificate will ordinarily contain this information, it is important to complete this item and provide information on the nature of the accident if known.

Once MLIC receives the *Notice of Death* and all the necessary supporting documents, MLIC will:

- identify eligible beneficiaries,
- request any additional documents necessary,
- communicate with the beneficiaries directly about the death benefits that are payable.

If there are any questions concerning the claim, please contact MLIC at (608) 277-8690.

Premiums

Premiums are payable through the month of death. Advance premiums deducted for any period after the date of death must be refunded.

1501 *Notice of Death* (ET-6301)

MINNESOTA LIFE **NOTICE OF DEATH**

Minnesota Life Insurance Company • P.O. Box 259708 • Madison, WI 53725-9708 • For Further Information Call: 608-277-8690

NAME (LAST)	FIRST	MIDDLE	MAIDEN

ADDRESS (STREET)	CITY	STATE	ZIP CODE

SOCIAL SECURITY NUMBER	BIRTHDATE (Mo/Day/Yr)	DATE OF DEATH (Mo/Day/Yr)

EMPLOYER NAME

LAST DAY WORKED (Mo/Day/Yr)	LAST DAY ON PAYROLL (Mo/Day/Yr)	PREMIUMS COLLECTED BY EMPLOYER FOR COVERAGE THROUGH (Mo/Yr)

TERMINATION OF ACTIVE EMPLOYMENT OCCURRED BECAUSE OF

IS THERE EVIDENCE THAT DEATH MAY HAVE BEEN ACCIDENTAL

☐ YES ☐ NO IF YES , PLEASE EXPLAIN

AMOUNT OF INSURANCE IN FORCE

	Municipal Employe	State Employe
Basic Life Coverage	$	$
Supplemental Coverage		
Additional Coverage		
Accidental Death Benefit, if Applicable		
TOTAL INSURANCE PAYABLE	$	$

Possible Beneficiaries or Contact Named Below

NAME				ADDRESS			
Last	First	Middle	Relationship	Street	City	State	Zip Code

I understand that Wisconsin Statutes, s. 943.395, provide criminal penalties for knowingly making false or fraudulent claims on this form and hereby certify that, to the best of my knowledge and belief, the above information is true and correct.

SIGNATURE OF EMPLOYER'S AUTHORIZED REPRESENTATIVE	DATE (Mo/Day/Yr)
X	

ET-6301 (formerly GI-33) (REV 12/84)

F. 47301 Rev.10-1998

1502 Death Benefit Claim - Annuitant and Inactive

ETF is usually notified of the death of an annuitant or inactive employee either by a family member or through an obituary. However, if you become aware that a former employee has died, notify ETF toll-free at (877) 533-5020 or 266-3285 (local Madison) or call MLIC at (608) 277-8690. If possible, supply the name, address, or telephone number of the spouse, personal representative, or other contact person.

Upon receipt of the necessary information, ETF will initiate processing of both the WRS survivor benefits and the life insurance claim. ETF will notify MLIC that the claim is payable and will provide beneficiary information. MLIC will contact the beneficiary(ies) of the life insurance to obtain the documentation necessary to process the claim.

1503 Death Benefit Claim - Spouse or Dependent

A *Notice of Death of Spouse or Dependent Child* (ET-6303) must be submitted to ETF upon the death of an insured spouse or dependent child. (See the sample form in Subchapter 1504.)

To file a claim:

A. The employee completes the top portion of the *Notice of Death of Spouse or Dependent Child* (ET-6303).

B. Signatures of both the employee and employer agent are required.

C. A certified copy of the death certificate, if available, should accompany the notice. NOTE: If it is not immediately available, submit the *Notice of Death of Spouse or Dependent Child* (ET-6303) without it.

D. Upon receipt, ETF will process and forward the notice on to MLIC for payment. MLIC will contact the beneficiary(ies) to obtain the necessary documentation to complete the processing of the death claim.

The sole beneficiary of Spouse and Dependent coverage is the employee. In the case of simultaneous deaths of the employee and the spouse or dependent child, payment will be made to the employee's estate. Should simultaneous deaths occur, the court-appointed personal representative of the estate should sign the Notice of Death. A certified copy of the legal appointment, along with certified copies of all death certificates, should be submitted with the Notice of Death.

If the employee dies before the insured spouse or dependent, or intentionally and unlawfully kills the insured spouse or dependent, the benefit shall be paid to the insured spouse's or dependent's beneficiary in accordance with Wis. Stats. §40.02 (8), except that the person who intentionally and unlawfully kills the insured may not receive any benefit.

1504 *Notice of Death for Spouse or Dependent Child* (ET-6303)

Department of Employee Trust Funds
801 West Badger Road
P.O. Box 7931
Madison, Wisconsin 53707-7931

NOTICE OF DEATH FOR SPOUSE OR DEPENDENT CHILD
(Life Insurance)
Wis. Stat. § 40.70

Personally identifiable information, such as your Social Security number, date of birth, etc., will not be used for any purpose other than for the administration of the benefit programs administered by the Department of Employee Trust Funds.

COMPLETE AND RETURN TO YOUR EMPLOYER. ATTACH A CERTIFIED COPY OF THE DEATH CERTIFICATE.		Employee Social Security Number
Employee Name (Last, First, Middle, Previous)		Birthdate (MM/DD/CCYY)
Employer Name or State of Wisconsin Department		
Name of Deceased (Last, First, Middle, Previous)		Deceased's Social Security Number
Relationship to Employee	Birthdate (MM/DD/CCYY)	Date of Death (MM/DD/CCYY)

At the time of death, the deceased person indicated above was my:

- ☐ Spouse. Date of marriage _____.
- ☐ Dependent child. This child was unmarried and dependent upon me for at least 50% of support and maintenance, and was (check appropriate box):
  - ☐ More than 14 days of age, but under the age of 19.
  - ☐ Between the ages of 19 and 25 if a full-time student (last enrolled on _____ (MM/DD/CCYY)).
  - ☐ Age 19 or older and incapable of self-support on account of physical or mental disability which can be expected to be of long-continued or indefinite duration.

I understand that Wis. Stat. § 943.395 provides criminal penalties for knowingly making false or fraudulent claims on this form and hereby certify that, to the best of my knowledge and belief, the above information is true and correct.

Date (MM/DD/CCYY)	Employee Signature
Address (Street, City, State, Zip Code)	

****

Basic and Spouse and Dependent group life insurance coverage was in force and premium payments were current at the time of the deceased's death. The employee has ☐ one unit or ☐ two units of Spouse and Dependent coverage. A copy of the spouse and dependent application is attached.

Date (MM/DD/CCYY)	Signature of Employer Representative

FOR EMPLOYEE TRUST FUNDS USE ONLY

	By	Date
Completed		

	By	Date (MM/DD/CCYY)
Initial Processing Comp & Audited		
Received by Insurance Co.		
Benefit Paid		

ET-6303 (REV 10/98)

1505 Claim Notice and Proof for Accidental Dismemberment or Loss of Use Coverage

When an eligible employee loses a limb, or sight, or loses the use of a limb due to accidental causes, both the employer and the employee must complete a *Claim for Accidental Dismemberment or Loss of Use of Limbs or Eyes* (ET-6302). The claim forms may be obtained by contacting MLIC directly at (608) 277-8690. Instructions for filing a proof of loss will accompany the claim form.

This form, or a written notice of an injury on which a claim may be based, must be submitted to MLIC within 30 days after the accident, unless it is shown not to have been reasonably possible to give such notice prior to the date it is presented.

MLIC may require a claimant to be examined at MLIC's expense, while a claim is pending.

See Subchapter 304 for more information about accidental dismemberment or loss of use coverage.

1506 *Claim for Accidental Dismemberment or Loss of Use of Limbs or Eyes* (ET-6302)

MINNESOTA LIFE

ACCIDENTAL DISMEMBERMENT OR LOSS OF USE OF LIMBS OR EYES

Minnesota Life Insurance Company • P.O. Box 259708 • Madison, WI 53725-9708 • For Further Information Call: 608/277-8690

PART 1 - EMPLOYER STATEMENT

SOCIAL SECURITY NUMBER

EMPLOYEE NAME (Last, First, Middle Initial)

DATE OF BIRTH

EMPLOYEE ADDRESS (Street, City, State, Zip)

DATE OF ACCIDENT

AMOUNT OF INSURANCE IN FORCE ON DATE OF ACCIDENT

$

DATE COVERAGE FIRST BECAME EFFECTIVE FOR THIS INSURED EMPLOYEE

EMPLOYER NAME

ETF CODE

DATE SIGNED

SIGNATURE OF EMPLOYER

X

PART II - INSURED EMPLOYEE'S STATEMENT *(This statement is not complete unless all questions are answered fully and clearly.)*

ADDRESS WHERE YOU MAY BE CALLED UPON NOW (Street, City, State, Zip)

DESCRIBE HOW THIS ACCIDENT HAPPENED, INCLUDING PLACE AND LOCATION OF ACCIDENT

DESCRIBE INJURY AND RESULTING LOSS

AT THE TIME OF THE ACCIDENT, WERE YOU UNDER A PHYSICIAN'S CARE FOR TREATMENT OF ANY DISEASE OR ILLNESS? IF YES, PLEASE DESCRIBE

WHEN DID YOU FIRST CONSULT A PHYSICIAN AS A RESULT OF YOUR ACCIDENT?

DOCTOR'S NAME

DOCTOR'S FULL ADDRESS (Street, City, State, Zip)

DOCTOR'S PHONE NUMBER

( )

HAVE OTHER DOCTORS TREATED YOU AS A RESULT OF YOUR ACCIDENT? IF YES, PLEASE INCLUDE THEIR NAMES AND ADDRESSES:

☐ YES ☐ NO

The furnishing of this form by the company shall not constitute either an admission by it that disability insurance is in force or a waiver of any of the company's rights or defenses.

DATE SIGNED

SIGNATURE OF EMPLOYEE

X

For the purpose of determining my eligibility for insurance coverage and benefits, I authorize any provider of health care, physician, medical practitioner, psychologist, chiropractor, hospital, including Veterans Administration Hospital, clinic or other health care facility, insurance company, consumer reporting agency, Social Security Administration, Internal Revenue Service, financial institutions, employer, workers' compensation, rehabilitation facility or other organization or person which has any medical or nonmedical records or knowledge, including but not limited to my physical or mental health or financial information or employment, to give all such information it has to **Minnesota Life Insurance Company** (Company) or its authorized representative. This shall include but not be limited to information regarding any health history including all consultations, diagnoses, prescriptions, treatments, tests, as well as any information regarding alcohol or drug abuse, AIDS or AIDS-related conditions.

I authorize the Company to release any information relevant to my insurance coverage and claim for benefits to persons or organizations performing services related to the claim, to other insurance carriers with whom I have coverage, or to any other public or private entity as may be required.

I AUTHORIZE: Minnesota Life Insurance Company to request a report from the Medical Information Bureau (MIB), which is an association of life insurance companies that operates the Health Claim Index (HCI) for subscriber insurers. An HCI report contains the date(s) of past or present claims filed by me and the names of the companies but does not contain medical or other personal information. I understand **Minnesota Life Insurance Company** will report to MIB the date(s) of any past or present claims filed by me.

Upon receipt of a request from me, MIB will arrange a disclosure of any information it may have in my HCI file. If I question the accuracy of information in the file, I may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB, Inc.'s information office is PO Box 105, Essex Station, Boston, MA 02112, telephone number (617) 426-3660.

This authorization shall be valid for 30 months from the date it is signed. I have read and I understand this authorization. I know that I may request and receive a copy of it. A photocopy of this authorization is as valid as the original.

(V.A. Claim Number _____)

DATE SIGNED

SIGNATURE OF WITNESS

X

DATE SIGNED

SIGNATURE OF EMPLOYEE

X

NOTICE: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against the insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud. The commission of insurance fraud may subject such person to criminal and/or civil penalties. Any insurance company or agent of an insurance company who knowingly attempts to defraud a policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Division of Insurance.

F. 17904 Rev. 3-2001
ET-6302

1506 *Claim for Accidental Dismemberment or Loss of Use of Limbs or Eyes* (ET-6302) Continued

PART III ATTENDING PHYSICIAN'S STATEMENT

HISTORY

DATE ACCIDENT OCCURRED	DATE AMPUTATION OR LOSS OF SIGHT OCCURRED

LOCATION OF ACCIDENT (Work, etc.) DESCRIBE:

	Yes	No
Do you feel this patient is competent to endorse and direct the proceeds thereof?	☐	☐
Has patient ever had same or similar condition or prior disabilities?	☐	☐
At the time of the accident, amputation, or loss of sight, was the patient receiving care or treatment of any disease or illness?	☐	☐
Was the patient's dismemberment, total and permanent loss of use or loss of sight caused (directly or indirectly) by any physical or mental infirmity; illness or disease; self-inflicted injury: commission of a felony; drugs or poison taken voluntarily; bacterial infection; travel on any military aircraft; or war?	☐	☐

If answers to any of the above questions "yes", describe particulars in detail, including dates.

DISMEMBERMENT

	Yes	No
Was there an amputation resulting in severance through or above the wrist or ankle joint? If "yes", give complete description of dismemberment.	☐	☐

LOSS OF USE

	Yes	No
Did total loss of use of hand or foot from wrist or ankle occur as a result of the accident?	☐	☐
Did total loss of use of arm or leg from shoulder or hip occur as the result of the accident?	☐	☐

If yes, please provide details regarding the loss of use.

LOSS OF SIGHT

	Yes	No
Did total and irrecoverable loss of sight occur as a result of the accident?	☐	☐
Did total and irrecoverable loss of sight occur more than 180 days after the accident?	☐	☐

WHAT WAS VISION AT LAST OBSERVATION? (SNELLEN NOTATION)

WITH GLASSES	O.D.	O.S.	DATE
WITHOUT GLASSES	O.D.	O.S.	DATE

DATE CORRECTED VISION WAS IRRECOVERABLY REDUCED TO 20/200 OR LESS IN THE BETTER EYE

MONTH/DAY/YEAR

☐ O.D. ☐ O.S.

VISION CAN BE RESTORED IN WHOLE OR IN PART BY:

O.D.	☐ LENSES	☐ TREATMENT	☐ OPERATION	☐ NOT RESTORABLE
O.S.	☐ LENSES	☐ TREATMENT	☐ OPERATION	☐ NOT RESTORABLE

Please enclose copies of any visual fields testing that has been done.

PLEASE INCLUDE COPIES OF YOUR MEDICAL RECORDS PERTAINING TO THE LOSS

NAME OF ATTENDING PHYSICIAN (Please print)	DEGREE	TELEPHONE NUMBER
		( )

PHYSICIAN'S ADDRESS (Street, City, State, Zip)

SIGNATURE OF ATTENDING PHYSICIAN	DATE SIGNED	PRINT NAME OF PERSON COMPLETING THIS FORM
X		

1507 Applying for Living Benefits

Living benefits are the proceeds of the employee's life insurance coverage that are paid to the employee while the employee is still living rather than to the employee's beneficiaries after the employee's death. An eligible employee can apply for living benefits for up to the full value of the coverage in force. The applicant can be an insured employee, retiree or spouse or dependent child of an employee who has coverage under the Spouse and Dependent Plan. The applicant must meet certain medical criteria to qualify.

For information about applying for living benefits, refer to *Living Benefits* brochure (ET-2327). To request a copy call ETF at 608-266-3302 or visit our Internet site at etf.wi.gov.

1508 Converting Life Insurance to Pay Health Insurance Premiums or Long-Term Care Insurance

Insured retirees may be eligible to convert their basic group life insurance coverage to pay premiums for health insurance or long-term care insurance. For more information about converting life insurance to pay health insurance premiums or long-term care insurance, the employee may request *Converting Your Group Term Life Insurance to Pay Health Insurance Premiums* brochure (ET-2325) from ETF. The brochure is also available in the "Insurance Forms and Brochures" area on the ETF Internet site at etf.wi.gov. The employee should contact ETF to request an *Election to Convert Life Insurance to Pay Health Insurance or Long-Term Care Insurance Premiums* (ET-2324).